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	295055	A. BUILDING _____ B. WING _____	03/27/2009

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COLLEGE PARK REHABILITATION CENTER	2856 E. CHEYENNE AVE. NORTH LAS VEGAS, NV 89030

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare re-certification and complaint survey conducted at your facility from March 24, 2009 through March 27, 2009, in accordance with 42 CFR Chapter IV Part 483 Requirements for States and Long Term Care Facilities. The census at the time of the survey was 97. The sample size was 20 including 3 closed records. The following 2 complaints were investigated during the survey: CPT # 21052 Substantiated with deficiencies (Tags F279, F309) CPT # 21163 Substantiated with deficiencies (Tag F 309) The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial	F 279		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 279	Continued From page 1 needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a comprehensive care plan was updated to meet the resident's needs for 5 of 20 residents (#10, #14, #19, #5, #11). Findings include: Resident #10 Resident #10 was a 58 year old male admitted to the facility on 11/8/07 and readmitted on 7/26/08 with diagnoses including Convulsions, Hypertension, Schizophrenia, and Dysphagia. Documentation in the Nurse's notes indicated: 12/31/08 "Pt (patient) found on floor by CNA (Certified Nursing Assistant)..." Resident # 10's care plan last reviewed 3/9/09 indicated: - "Last Fall: 8/26/08"	F 279		

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There was no documented evidence in Resident #10's medical record that a fall assessment was completed or the care plan was updated following the resident's fall on 12/31/08.

There was no documented evidence in Resident #10s medical record that the care plan was completed for the resident's diagnosis of Convulsions.

On 3/26/09 in the afternoon, the Director of Nurses confirmed the care plan had not been updated after the resident's fall. There was no care plan for the resident's diagnosis of Convulsions.

Resident #14

Resident #14 was a 62 year old female readmitted to the facility on 1/2/09 with diagnoses including Fracture of Right Hip with Open Reduction and Internal Fixation, End Stage Renal Disease, Legally Blind, Seizure Disorder, and Depression.

Resident #14's care plan indicated the resident had fallen on 12/27/08, 1/19/09, 1/28/09, 2/1/09. There was no documented evidence that the care plan was updated following her falls in January and February, 2009.

The care plan was reviewed and updated on 3/2/09 to include:
- Room close to nursing station,
- RA (Restorative Aide) for ambulation and strengthening as ordered, and
- Tab alarm as ordered.

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F 279	Continued From page 3 There was no documented evidence in Resident #14's medical record that the care plan was completed for the resident's diagnosis of Seizure Disorder. On 3/26/09 in the afternoon, the Director of Nurses confirmed the care plan had not been updated after the resident's falls. She also confirmed there was no care plan for the resident's diagnosis of Seizures. CPT #21052 Resident #19 Resident #19 was a 48 year old female admitted to the facility on 2/25/09, with diagnoses including Chronic Pancreatitis, Convulsions, history of Respiratory Failure, status post Pulmonary Embolism, a history of Renal Cell Carcinoma with Metastasis to brain, and status post right Nephrectomy. Resident #19 was admitted to the hospital on 2/13/09 for respiratory failure status post seizure per her hospital history and physical. Resident #19 had a Physician's Order dated 2/26/09 for Dilantin 300 milligrams twice a day. Resident #19's Comprehensive Plan of Care, dated 2/26/09, contained no documentation that addressed the resident's seizure disorder. Resident #5	F 279		

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Resident #5 was a 52 year-old male resident originally admitted to the facility on 8/12/08 and re-admitted on 3/19/09, with diagnoses including Anemia, Protein Calorie Malnutrition, Pleural Effusion, Bacteremia, Schizophrenia, History of Hepatitis C, Chronic Obstructive Pulmonary Disease and Status Post Right Thoracic Decortication, Status Post Thoracotomy.

Review of the resident's record on 3/24/09, revealed a single Comprehensive Plan of Care for an "unstageable Rt. (right) Outer heel" pressure sore. The record contained no evidence of an Interim Plan of Care completed upon the resident's re-admission. The Interim Plan of Care reviewed on 3/24/09, was not initiated and completed.

Following the initial review of the resident's record on 3/24/09, a second review was completed on 3/25/09, which revealed Comprehensive Plans of Care in the record from a previous admission and not related to Resident #5's current admission. The resident's re-admission skin assessment on 3/20/09, revealed a PEG (Percutaneous Endoscopic Gastrostomy) Tube site, right lateral chest (status post Thoracotomy), and right outer ankle pressure sore.

Care plans placed in the resident's record on 3/25/09, were dated 1/8/09, with plan of care for "stage III pressure ulcer to buttock area", "unstageable rt. (right) heel", "stage III lt. (left) gluteal fold" and "stage II mid-spine". During the re-admission skin assessment on 3/20/09, there was no indication of the above skin issues.

Further review indicated no care plans for the

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resident's mental illness diagnosis (Schizophrenia) which was being treated (Risperdal and Depakote), risk for falls (assessed as high risk on 3/19/09), and for a PICC (Percutaneous Inserted Central Catheter) line which was in-place prior to the resident's re-admission.

Resident #11

Resident #11 was a 61 year-old female resident admitted to the facility on 3/3/09, with diagnoses including Abnormality of Gait, Chronic Obstructive Pulmonary Disease, Chronic Airway Obstruction, Lack of Coordination, General Muscle Weakness, Hypertension and Obsessive Compulsive Disorder.

The Nurse's Notes dated 3/4/09 at 0945 (9:45 am), revealed the resident was found on the floor next to the door of her bedroom. It was indicated in the note the resident was unaware of what happened prior to the alleged accident

The Daily Skilled Nurses Notes dated 3/14/09 at 1430 (2:30 PM), indicated the charge nurse observed the resident was naked attempting to ambulate in the hallway. It was noted that the charge nurse while assisting the resident back to her room, the resident "fainted intentionally" but didn't hit her head or suffer any apparent injury.

The Physician Telephone Orders dated 3/14/09, indicated an order for placement of a Tab Alarm while up in the wheelchair and also in bed to alert staff of unassisted transfers and ambulation.

The resident's plan of care for risk of falls, dated 3/4/09, indicated the resident was a risk for falls

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F 279	Continued From page 6 and noted on the plan was one fall on 3/4/09. The plan of care was not updated for the second fall on 3/14/09. There was no evidence of documentation on the plan of care that supported the new order for the resident's Tab Alarm and date of its initiation as an approach to eliminate future falls.	F 279		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and document review, the facility failed to ensure correct placement of a gastrostomy tube according to established standards on 1 of 20 residents (#10). Findings include: Resident #10 Resident #10 was a 58 year old male admitted to the facility on 11/8/07 and readmitted on 7/26/08 with diagnoses including Convulsions, Hypertension, Schizophrenia, and Dysphagia. Resident was receiving Gastrostomy tube (G-tube) feedings of Isosource 1.5 at 80 cc (cubic centimeter)/hour. On 3/26/09 in the afternoon, observed RN (Registered Nurse) administer medications through Resident #10's G-tube. - The RN checked for bowel sounds by injecting 30 ml (milliliters) of air via a syringe into the G-tube and listened to the resident's abdomen	F 281		

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F 281	Continued From page 7 with a stethoscope. - The RN inserted approximately 30 ml of water and monitored for patency. - The RN then inserted each medication which was crushed and dissolved in water. - The RN inserted 30cc's of water into the tube between each medication. - When all the medication was administered, the RN changed the tubing and reconnected the G-tube feeding. The RN did not check for a residual prior to administering Resident #10's medications or starting the next tube feeding. Facility policy titled Enteral Feeding - General Guidelines, dated 2006, revealed: Procedures: 4. "Verify correct tube placement at least every eight (8) hours: A. "Prior to beginning a feeding/flushing." B. Administering medication..." by "A. Checking for gastric residual: 1) If volume 150 ml or less re insert residual and continue feeding. 2) If volume is greater than 150 ml, discard, HOLD FEEDING. Notify physician..."	F 281		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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F 309	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that residents were maintained at their highest level of well being for 6 of 20 residents (#5 #10, #14, #19, #22, #21). Findings include: Resident #5 Resident #5 was a 52 year-old male resident originally admitted to the facility on 8/12/08 and re-admitted on 3/19/09, with diagnoses including Anemia, Protein Calorie Malnutrition, Pleural Effusion, Bacteremia, Schizophrenia, History of Hepatitis C, Chronic Obstructive Pulmonary Disease and Status Post Right Thoracic Decortication, Status Post Thoracotomy. Review of the Physician Initial Admission Orders, dated 3/19/09, indicated a treatment order for Albuterol/Atrovent unit dose SVN (small volume nebulizer) every 6 hours. Review of the Physician's Telephone Orders, dated 3/20/09, indicated an order for a Multivitamin with Minerals 1 tablet by mouth every day for nutritional supplement. The resident's Medication Administration Record (MAR) for March 2009, indicated both the Multivitamin with Minerals and the treatment order for Albuterol/Atrovent were transferred onto the MAR, but both were not documented as administered to the resident during the record review on 3/24/09.	F 309		

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F 309	Continued From page 9 During an interview on 3/24/09 at 1:45 PM, Resident #5 was unable to verify that he had received the Multivitamin with Minerals and his SVN treatments. During an interview on 3/24/09 at 2:00 PM, the medication nurse assigned to Resident #5 acknowledged that there were no initials which indicated the resident was administered the medications as ordered by the physician. There was no documented evidence the resident received the Multivitamin with Minerals and his respiratory treatments. Resident #10 Resident #10 was a 58 year old male admitted to the facility on 11/8/07 and readmitted on 7/26/08, with diagnoses including Convulsions, Hypertension, Schizophrenia, and Dysphagia. 1.) Resident #10 was observed lying on his back in his bed with the side rails up on the following dates: - 3/25/09 in the morning and afternoon - 3/26/09 in the morning and afternoon - 3/27/09 in the morning There were no pads on the side rails and no airway protector at the bedside. The facility policy titled Seizure - Precautions and Support, dated 3/2006, revealed: Policy 2. "Seizure precautions will be implemented for patients/residents who have a recent history of seizures, head injury, and head surgery."	F 309		

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Procedures:
1. "Provide padded bedside rails and an airway at the bedside, when indicated." There was no documented evidence in Resident #10s medical record that the care plan was completed for the resident's diagnosis of Convulsions.

Documentation in the Nurse's notes indicated: 12/31/08 "Pt (patient) found on floor by CNA (Certified Nursing Assistant)..."

2.) Resident # 10's care plan last reviewed 3/9/09 indicated:
- "Last Fall: 8/26/08"

The facility policy titled Fall Management dated 3/2006 indicated:
Procedures:
5. "If a fall occurs, the qualified staff assesses for injury from the fall, immediately investigates the reason and determines the intervention to prevent future falls - complete the Fall Investigation Worksheet #FFNP049."

There was no documented evidence in Resident #10's medical record that a fall assessment was completed or the care plan was updated following the resident's fall on 12/31/08.

3.) On 3/26/09 in the afternoon, observed Employee #12 administer medications through Resident #10's G-tube (gastrostomy feeding tube) in the following manner:

- checked for bowel sounds by injecting 30 ml (milliliters) of air via a syringe into the G-tube and listened to the resident's abdomen with a stethoscope.
- inserted approximately 30 ml of water and

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monitored for patency
- then inserted each medication which was crushed and dissolved in water
- inserted 30cc of water into the tube between each medication
- When all the medication was administered, changed the tubing and reconnected the G-tube feeding

Employee #12 did not check for residual prior to administering Resident #10's medications or starting the next tube feeding.

Facility policy titled Enteral Feeding - General Guidelines dated 2006 revealed:
Procedures:
4. "Verify correct tube placement at least every eight (8) hours:
A. "Prior to beginning a feeding/flushing."
B. Administering medication..."
by
"A. Checking for gastric residual:
1) If volume 150 ml or less re insert residual and continue feeding.
2) If volume is greater than 150 ml, discard, HOLD FEEDING. Notify physician..."

Resident #14

Resident #14 was a 62 year old female readmitted to the facility on 1/2/09, with diagnoses including Fracture of Right Hip with Open Reduction and Internal Fixation, End Stage Renal Disease, Legally Blind, Seizure Disorder, and Depression.

On 3/26/09 in the afternoon, Resident #14 was lying in her bed on her side. The side rails were down and there was no airway protector in her

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room.

On 3/27/09 in the morning, Resident #14 was lying in her bed on her side with 1/2 side rails up. There was no padding on the side rails and no airway protector in the room.

The facility policy titled Seizure - Precautions and Support, dated 3/2006, revealed:
Policy
2. "Seizure precautions will be implemented for patients/residents who have a recent history of seizures, head injury, and head surgery."
Procedures:
1. "Provide padded bedside rails and an airway at the bedside, when indicated."

Resident #19

Resident #19 was a 48 year old female admitted to the facility on 2/25/09, with diagnoses including Chronic Pancreatitis, Convulsions, History of Respiratory Failure, status post Pulmonary Embolism and a history of Renal Cell Carcinoma with Metastasis to the brain post Right Nephrectomy. The resident left the facility on 3/3/09 at 9:08 AM.

The initial Physician's Orders dated 2/25/09, documented the following medication orders:

1. Dilantin 300 milligrams (mg) PO (by mouth) bid (twice a day)
2. Pancrelipase 4 tabs (tablets) PO tid (3 times a day)
3. Hydralazine 50 mg PO q (every) 8 hours
4. Protonix 40 mg daily
5. Lopressor 50 mg PO bid

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6. Fioricet 1 tab PO q 6 hours PRN (when necessary) for severe headache
7. Soma 1 tab PO every 8 hours PRN back spasm
8. Dilaudid 2 mg PO q 4 hours PRN moderate pain

A laboratory report for Resident #19 dated 2/26/09, indicated the Phenytoin (Dilantin) level was very low at 1.0 (normal range is 10.0-20.0)

A review of the Medication Administration record for Resident #19 dated 3/2009, indicated the resident received her medications as ordered on 3/1/09 and 3/2/09.

There was no documentation that the resident received her medications on 2/25/09, 2/26/09, 2/27/09 or 2/28/09.

On 3/27/09, the Medical Records Technician indicated all the Medication Administration Records (MAR's) for Resident #19 had been provided.

Complaint #NV21163

Resident #22

Resident #22 was an unsampled resident observed during the 11:00 AM Glucometer (blood sugar) checks on 3/25/09.

On 3/25/09 at 11:14 AM, Employee #17 administered a Glucometer check to Resident #22. The blood glucose level reading for the resident measured at 36. Employee #17 asked the resident how he felt. Resident #22 indicated he was all right. The resident indicated he had not

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eaten yet.

Employee #17 went to the medication cart and indicated she was going to give the resident Glucagon paste. She was unable to find Glucagon paste in the medication cart. She went to the other medication carts and was unable to find Glucagon paste.

Employee #17 informed the Charge Nurse there was no Glucagon paste on any of the medication carts and the blood glucose level for Resident #22 was 36. The Charge Nurse instructed Employee #17 to give the resident a glass of orange juice.

Employee #17 administered an 8 ounce glass of orange juice to Resident #22 at 11:35 AM.

On 3/25/09 at 12:40 PM, the Charge Nurse indicated Resident #22's blood glucose level measured at 86.

Document Review

The facility policy titled The treatment of Hypoglycemia Policy, contained the following information:
1. Assess patient/resident symptoms.
2. Perform and document bedside blood glucose level according to procedures from, "Bedside Blood Glucose Monitoring."
3. Treat immediately, even if biochemical hypoglycemia is not present with:
A. Ten to fifteen (grams of rapidly absorbed carbohydrates
1. Four ounces (oz.) of fruit juice
2. Four oz. of soda, not diet
3. Three five grams each of over the

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F 309	Continued From page 15 counter glucose tablets 4. One cup of milk 4. Have patient rest. 5. Repeat blood glucose level in 15 minutes. 9. Assess probable cause and notify the physician..." The Daily Skilled Nurses Notes dated 3/25/09 at 11:15 AM, indicated, "...At 11:15 AM blood sugar was 36 with no symptoms noted. orange juice 1 glass was given. BS (blood sugar) was 86 1 hour later. Will continue to monitor low blood sugar..." Resident #21 Resident #21 was a 45 year old admitted on 7/11/06, with medical diagnoses including Down's Syndrome, Hypertension, Coronary Artery Disease, Hypothyroidism, and Diabetes Type II. Resident #21 received a scheduled dose of insulin twice daily and insulin coverage as needed (sliding scale) twice a day at 7:00 AM and 4:00 PM based on fingerstick blood sugar results. On 3/25/09 at 4:10 PM, Resident #21's fingerstick blood sugar result was 241 mg/dL (milligram per deciliter). Following the fingerstick blood sugar, the resident received 4 units of Regular Novolin insulin subcutaneously (SQ) in the right upper arm. The March, 2009 Physician's Orders for the as needed (sliding scale) insulin coverage included the following orders: - Accucheck (fingerstick blood sugar) AC (before meals) and HS (hour of sleep) with the following sliding scale coverage:	F 309		

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F 309	Continued From page 16 - < (less than) 150 = no coverage, - 150 - 200 = 4 units Regular insulin SQ, - 201 - 250 = 6 units Regular insulin SQ, - 251 - 300 = 8 units Regular insulin SQ, - 301 - 350 = 10 units Regular insulin SQ, - 351 - 400 = 12 units Regular insulin SQ, and - > (greater than) 401 = call MD (physician). The Physician's Orders for the as needed (sliding scale) insulin coverage were unchanged from December, 2008 through March, 2009. The Diabetic Flow Sheet for the months of March, 2009, February, 2009, January, 2009, and December, 2008 contained documentation for the as needed (sliding scale) insulin coverage and included the following handwritten orders: - 70 = give OJ (orange juice) and call MD, - 71 - 150 = no units SQ, - 151 - 200 = 2 units SQ, - 201 - 250 = 4 units SQ, - 251 - 300 = 6 units SQ, - 301 - 350 = 8 units SQ, - 351 - 400 = 10 units SQ, and - > 400 = give 10 units and call MD. Resident #21 did not receive the as needed (sliding scale) Regular insulin coverage as ordered by the physician during the months of December, 2008, January, 2009, February, 2009 and through March 25, 2009.	F 309		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315		

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who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the faciity failed to ensure appropriate evaluation of residents for an indwelling Foley catheter for 2 of 20 residents (#9, #12).

Resident #9

Resident #9 was a 70 year old male admitted to the facility on 8/18/08 and readmitted on 2/13/09, with diagnoses including Cerebral Vascular Accident (CVA), Leukocytosis, Urinary Tract Infections, Diabetes, and General Muscle Weakness.

Nursing Assessment dated 2/13/09 revealed Resident #9 had a Foley Catheter in place.

The medical record lacked documented evidence of the following:
- a physician order for the Foley catheter,
- medical justification for continued use of the Foley catheter, and
- attempts to discontinue the Foley catheter.

Resident #9"s care plan dated 2/13/09 revealed:
-"Foley catheter placement secondary to severe debility from disease process. History of CVA. Patient unable to assist with toileting program."

On 3/26/09 in the afternoon, Resident #9 was observed lying in bed. He was alert, oriented and

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able to move his upper extremities. The tubing of the Foley catheter urinary drainage bag was cloudy and the urinary drainage bag was lying on the floor.

Resident #9 stated he had the catheter in place for some time. He did not know how long the tube was in place. He indicated he had never been asked about having the the Foley catheter removed.

On 3/27/09 in the morning, the Director of Nurses (DON) confirmed there was no order for the Foley catheter. She proceeded to have the charge nurse call the physician for an order for the Foley catheter.

Resident #12

Resident #12 was a 76 year-old male resident admitted to the facility on 2/4/09, with diagnoses including History of Fall, Hypertension, General Muscle Weakness, Status Post Fracture Neck of Femur, Abnormality of Gait and Cerebrovascular Accident.

The resident's plan of care for Incontinent of bowel and bladder, dated 2/11/09, indicated the resident was incontinent of both bowel and bladder. In the plan, it was indicated that the resident would be assessed for the causes of incontinence, however, there was no documented evidence of an assessment maintained in the resident's record.

Copies of an Assessment of Urinary Elimination and Bowel Retraining Assessment were contained in the resident's record, but both

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F 315	Continued From page 19 assessments were not initiated and completed.	F 315		
F 333 SS=D	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents were free from significant medication errors for 2 of 21 residents (#16, #21). Findings include: Resident #16 was a 76 year old male admitted on 6/3/09, with diagnoses to include Aphasia, Hypertension and Cardiovascular Disease. Resident #16 had a physician's Order dated 1/9/09 for Plavix 75 mg (milligrams) QD (everyday). The resident's Medication Administration Record indicated the resident received Plavix at 8:00 AM. During the morning medication pass on 3/25/09, the nurse omitted administration of the medication to the resident. Resident #21 Resident #21 was a 45 year old admitted on 7/11/06 with medical diagnoses including Down's Syndrome, Hypertension, Coronary Artery Disease, Hypothyroidism, and Diabetes Type II. Resident #21 received a scheduled dose of insulin twice daily and insulin coverage as needed (sliding scale) twice a day at 7:00 AM and 4:00	F 333		

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F 333	Continued From page 20 PM based on fingerstick blood sugar results. On 3/25/09 at 4:10 PM, Resident #21's fingerstick blood sugar result was 241 mg/dL (milligram per deciliter.) Following the fingerstick blood sugar, the resident received 4 units of Regular Novolin insulin subcutaneously (SQ) in the right upper arm. The March, 2009 Physician's Orders for the as needed (sliding scale) insulin coverage included the following orders: - Accucheck (fingerstick blood sugar) AC (before meals) and HS (hour of sleep) with the following sliding scale coverage: - < (less than) 150 = no coverage, - 150 - 200 = 4 units Regular insulin SQ, - 201 - 250 = 6 units Regular insulin SQ, - 251 - 300 = 8 units Regular insulin SQ, - 301 - 350 = 10 units Regular insulin SQ, - 351 - 400 = 12 units Regular insulin SQ, and - > (greater than) 401 = call MD (physician.) The Physician's Orders for the as needed (sliding scale) insulin coverage were the same for March, 2009, February, 2009, January, 2009, and December, 2008. The Diabetic Flow Sheet for the months of March, 2009, February, 2009, January, 2009, and December, 2008 contained documentation for the as needed (sliding scale) insulin coverage and included the following handwritten orders: - 70 = give OJ (orange juice) and call MD, - 71 - 150 = no units SQ, - 151 - 200 = 2 units SQ, - 201 - 250 = 4 units SQ, - 251 - 300 = 6 units SQ,	F 333		

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F 333	Continued From page 21 - 301 - 350 = 8 units SQ, - 351 - 400 = 10 units SQ, and - > 400 = give 10 units and call MD. Resident #21 received the following number of incorrect doses of as needed (sliding scale) Regular insulin: - 14 incorrect doses from March 1 - 11, 2009, - 37 incorrect doses in February, 2009, - 38 incorrect doses in January, 2009, and - 20 incorrect doses in December, 2008. Resident #21 received incorrect amounts of Regular insulin for as needed insulin coverage throughout the months of March, 2009, February, 2009, January, 2009, and December, 2008.	F 333		
F 372 SS=B	483.35(i)(3) SANITARY CONDITIONS - GARBAGE DISPOSAL The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility did not dispose of garbage properly. Findings include: On 3/27/09 in the midafternoon, the Dietary Manager acknowledged 2 dumpsters placed in the back of the building were not covered/closed with the attached lids. The 2 dumpsters were observed open to air.	F 372		
F 431 SS=E	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431		

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F 431	Continued From page 22 of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure expired medications were disposed of in accordance with facility practices. Findings include:	F 431		

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F 431	Continued From page 23 On 3/24/09 in the morning, during an inspection of the Medication Room the following medications were found to be expired: an Intravenous bag of Vancomycin 1.25 grams in a 250 milliliter solution of 0.9% normal saline and water, expiration date 3/9/09. The refrigerator in the medication room contained the following: - one syringe containing Fragmin 5700 units with an expiration date of 1/20/09, - thirteen syringes containing Fragmin 5700 units with expiration dates of 2/3/09, 2/5/09, 2/9/09, 2/10/09, 2/11/09 and 2/13/09, - thirty syringes containing Fragmin 5700 units with expiration dates of 3/01/09, 3/2/09, 3/3/09, 3/7/09, 3/9/09, 3/10/09, 3/13/09, 3/20/09 and 3/23/09. On the morning of 3/24/09, Employee #16 and the Director of Nurses indicated the pharmacy routinely came once a week to remove the expired medications. Employee #16 indicated the expired medications belonged to a resident who was were either discharged or went to the hospital and returned to the facility. On the morning of 3/25/09, the Pharmacy Representative indicated the expired medications were supposed to be put in a red bin for disposal. He indicated he had just put a new red bin in the medication room.	F 431		
F 514 SS=C	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional	F 514		

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F 514	Continued From page 24 standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain complete and accurate clinical information for all residents that was readily accessible, for 17 of 20 residents. Findings include: On 3/26/09 at 9:20 AM, a licensed practical nurse (LPN) described reviewing the upcoming monthly Physician's Orders (recapitulation orders) and telephone orders for completeness and accuracy "3 - 4 days before the end of month." The reviewed monthly Physician's Orders (recapitulation orders) were then placed on physician clipboards for physician signatures. The signed monthly Physician's Orders were filed in the residents' medical records at the start of every month. On 3/26/09 at 10:00 AM, the medical records technician described filing the monthly Physician's Orders in every resident's chart at the start of a new month. The monthly orders for February, 2009 and March, 2009 were not placed in the residents' medical records because a medical	F 514		

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F 514	Continued From page 25 records assistant "quit and left abruptly." On 3/24/09, 3/25/09, and 3/26/09, the monthly Physician's Orders (recapitulation orders) for February, 2009 and March, 2009 were not available in the sampled residents' medical records.	F 514		